2009 DRAFTING REQUEST

Bill

Received: **01/15/2009**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget**

By/Representing: **Willing**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies:

Submit via email: **YES**

Requester's email:

Carbon copy (CC:) to: **Sue.Jablonsky@Wisconsin.gov**

Pre Topic:

DOA:.....Willing, BB0426 -

Topic:

Health insurance reform initiatives

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 01/15/2009						S&L
/P1	pkahler 01/16/2009	jdyer 01/20/2009	mduchek 01/15/2009 phenry 01/20/2009		lparisi 01/20/2009		S&L
/P2	pkahler 01/27/2009	jdyer 01/27/2009	phenry 01/27/2009		mbarman 01/28/2009		S&L

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/P3	pkahler 01/29/2009	bkraft 01/29/2009	jfrantze 01/29/2009	_____ _____	cduerst 01/29/2009		

FE Sent For:

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler	PJ jld	1/20 ph	1/20 ph 1/21 gf			

FE Sent For:

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2009-11 Budget Bill Statutory Language Drafting Request

- Topic: Health Insurance Reform Initiatives
- Tracking Code: BB0426
- SBO team: Health and Insurance
- SBO analyst: Krista Willing
  - Phone: 267-7980
  - Email: krista.willing@wisconsin.gov
- Agency acronym: DHS
- Agency number: 435
- Priority (Low, Medium, High): High

Intent:

Make several changes in statute focused on Health Care Reform. Please see changes listed in attached paper. I believe Pam Kahler has already begun drafting these for OCI.

Please feel free to call me with any questions!

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

DATE: January 12, 2009

TO: Senator Kathleen Vinehout

FROM: Sean Dilweg, Commissioner

SUBJECT: Health Care Reform Initiatives

In follow up to our December 16, 2008 meeting, below is a summary of the health care reform initiatives you expressed an interest in pursuing.

Health Insurance Coverage for Adult Children

Proposal:
At the policyholder's request, require group and individual health insurance policies to cover unmarried adult children through 26 years of age under their parents' policies. The cost of coverage for adult children 19 through 26 years of age shall be included in the premium on the same basis as other dependent coverage. Insurers may require a policyholder seeking coverage for an adult child to provide written documentation on an annual basis that the adult child meets necessary requirements.

Adult children **excluded** from such coverage:

- Adult children who are eligible for comprehensive coverage under a group health plan offered by their employer for which the adult child's premium contribution is the same or less than the employee premium contribution for coverage as a dependent under their parent's health plan.

In addition to adult child coverage through the age of 26, also require group and individual health insurance policies to cover any child, regardless of age, under their parent's policy whose education is interrupted by services in the National Guard or Reserves.

Health Insurance Risk Sharing Plan (HIRSP)...2 Proposals

1. Certain individuals seeking eligibility into HIRSP must demonstrate that they have, in the past 9 months prior to application, received a notice of rejection from 2 or more insurers.

   Proposal:
   Revise s.149.12 (1) (a) to allow for a rejection notice from "1 or more insurers."

The change from 1 to 2 rejection notices was effective July 1, 2006 under 2005 Act 74.

2. Major medical expense coverage offered under HIRSP is currently subject to a lifetime limit of $1,000,000.

Proposal:
Revise s. 149.14 to read: Major medical expense coverage offered under the plan under this section shall pay an eligible person's covered expense, subject to deductible, co-payment and coinsurance payments, up to a lifetime limit of $1,000,000 or higher by the authority per covered individual.

Maximum Pre-existing Condition Exclusion Period for Individual Health Insurance Coverage

The Kaiser Family Foundation explains the "maximum pre-existing condition exclusion period" as a limit on post-claims underwriting. Any claim filed during the exclusion period can be investigated as possibly pre-existing and, if found to be so, can be denied and coverage for all further care for that condition can be excluded during the exclusion period.

The current pre-existing condition exclusion period for individual health insurance coverage in Wisconsin is 2 years.

Proposal:
Revise s. 632.76 (2) so that the pre-existing condition exclusion period for individual health insurance coverage is 1 year.

According to a Kaiser Family Foundation Fact Sheet, 23 other states use a 1 year pre-existing condition exclusion period.

Maximum Pre-existing Condition Look Back Period for Individual Health Insurance Coverage

The Kaiser Family Foundation explains the, "maximum look back period" as limiting the period of history preceding purchase of a policy that can be investigated for evidence of a preexisting condition.

Current law does not place a limit on the maximum look back period.

Proposal:
Limit the "maximum look back period" for pre-existing conditions to 1 year.

A 1 year maximum look back period means the following:

If an insured makes a claim for health care services within the maximum exclusion period, his or her medical history dating back 1 year prior to the purchase of his or her policy can be investigated for evidence that the current health problem existed prior to the purchase of coverage.

Move from Use of the "Prudent Person Standard" to the "Objective Standard" in Determining Whether a Pre-Existing Condition was Present Prior to Application for Coverage

Current law references the "prudent person standard" in determining whether a pre-existing condition was present prior to the individual's date of enrollment for coverage by an individual health plan.

Prudent Person: Includes conditions that were never diagnosed, but which exhibited symptoms for which an ordinary prudent person would have sought medical advice, care or treatment. (Kaiser Family Foundation Fact Sheet)

Objective Standard: Allows only those conditions for which someone actually received medical advice, diagnosis, care or treatment prior to enrollment to be counted as pre-existing. (Kaiser Family Foundation Fact Sheet)

Wisconsin currently applies the "objective standard" to Medicare Supplement policies:

> 632.76(2)(b) …A Medicare Supplement policy…may not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician…

Proposal:
Apply the "objective standard" to individual health insurance coverage.

Modification of Coverage at Renewal without the Application of Additional Underwriting

Proposal:
(a) An insurer that issues an individual major medical or comprehensive health benefit plan shall permit an insured, at any renewal, to change his or her coverage, to a comparable product currently offered by that insurer or a product currently offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. The insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage and shall receive credit under the coverage for the period of original coverage.

(b) An insurer issuing a policy under par. (a) may not rate for health status other than on the insured's health status at the time the original application was taken and based on health status required to be disclosed by the original application.

(c) An insurer shall annually mail notice to each insured of the right to elect alternative coverage under this subsection, the alternatives available, and the procedure for making the election, at least 60 days, and not more than 3 months prior to the renewal date.

(d) Nothing in this subsection requires an insurer to issue alternative coverage if the insureds coverage may be non-renewed or discontinued under s. 632.7495 (2), (3) (b) or (4).

(e) For the purpose of this subsection:

1. "Individual major medical or comprehensive health benefit plan" includes coverage under a group policy underwritten on an individual basis and issued to individuals or families,

2. Group policies are subject to this subsection notwithstanding s. 600.01 (1) (b) 3 and 4.

Rescission/Pre-existing Condition Exclusion External Appeal

Current law allows for independent review of adverse and experimental treatment determinations.

Proposal:
Allow for independent review of rescissions and pre-existing exclusion denial determinations. Do so by referencing rescissions and pre-existing condition exclusion denial determinations within s. 632.835 (current law relating to independent review).

Include language indicating that nothing requires an insured to request independent review prior to commencing a civil action relating to a determination. A decision of an independent review organization regarding a rescission or pre-existing condition exclusion denial determination is not binding on the insured.

Annual Reporting

Proposal:
On or after January 01, 2010, every health insurer shall annually report to the Commissioner the total number of individual health insurance policies issued and the total number of individual health insurance policies where the insurer initiated a cancellation or rescission or completed a cancellation or rescission pursuant to the provision of this article for the preceding calendar year.

SOURCE: Section 29 10384.32 (a) AB 1945 (California -- passed August 2008)

Uniform Individual Major Medical Application Underwriting Questions

Wisconsin currently has a "Small Employer Uniform Employee Application for Group Health Insurance."

Proposal:

601.41 (10) (a) The commissioner shall, by rule, prescribe uniform individual major medical health insurance underwriting questions to be used on the individual major medical insurance health insurance application, and the format for the use of those questions on the application. For the purpose of this subsection, individual major medical health insurance policy includes group health insurance coverage provided on an individual basis through an association.

(b) After the effective date of the rule promulgated under this subsection an insurer may use only the prescribed underwriting application questions and format for individual major medical health insurance applications.

Creditable Coverage

The maximum pre-existing condition exclusion period for group health insurance policies is 12 months. Currently, if a person loses health insurance coverage but picks up coverage within **63** days, they can apply creditable coverage to the 12 month exclusion period.

Proposal:

Allow individuals who lose health insurance coverage and pick up new group coverage within **90** days, to apply creditable coverage to the maximum pre-existing condition exclusion period on the new group policy.

The proposal **changes the timeframe from 63 days to 90**, for the privately insured market. A person moving into a self-funded plan will not be impacted by this change.

This is a compilation of

LRB's: 910
911
912
1157
1158

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-1538/P1
PJK:...:md

DOA:.....Willing, BB0426 - Health insurance reform initiatives

FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** health insurance coverage denials for eligibility under the Health Insurance Risk-Sharing Plan; relating to:portability under group health benefit plans and independent review of insurance policy rescissions and preexisting condition exclusion denials under group and individual health benefit plans; preexisting condition exclusions, modifications at renewal, and establishing a standard application for individual health benefit plans; the lifetime limit under the Health Insurance Risk-Sharing Plan; coverage of dependents under health care plans and granting rule-making authority.

Analysis by the Legislative Reference Bureau

***** ANALYSIS FROM -0910/1 *****

The Health Insurance Risk-Sharing Plan (HIRSP) under current law provides health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, and persons who do not currently have health insurance coverage but who

were covered under certain types of health insurance coverage (creditable coverage) for at least 18 months in the past. Persons who are eligible for coverage under HIRSP on the basis of being denied coverage by a private insurer must have been denied coverage by two or more insurers. This bill changes that criterion for eligibility to a denial of coverage by one or more insurers.

***** ANALYSIS FROM -0911/P1 *****

Under current law, for purposes of determining how long a preexisting condition exclusion may be imposed under a group health benefit plan, if a person who enrolls in the group health benefit plan had other coverage before that enrollment, the person must be given credit for the time during which he or she was previously covered when determining how long a preexisting condition exclusion may be imposed under the new coverage. Previous coverage may not be counted for the credit, however, if the person did not have coverage for a period of 63 or more days before the person's new coverage commenced. This bill increases that amount of time, so that a person may get credit for previous coverage if it ended up to 90 days, rather than 63 days, before the person enrolled in the group health benefit plan.

Also under current law, every insurer that issues a group or individual health benefit plan must have an internal grievance procedure under which an insured may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. In addition, every insurer that issues a group or individual health benefit plan must have an independent review procedure for review, after the internal grievance procedure has been exhausted, of certain decisions that are adverse to an insured. The adverse decision must relate to the insurer's denial of treatment or payment for treatment that the insurer determined was experimental or to the insurer's denial, reduction, or termination of a health care service or payment for a health care service on the basis that the health care service did not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. An independent review may be conducted only by an independent review organization that has been certified by the Commissioner of Insurance (commissioner).

The bill adds the rescission of a policy or certificate and a coverage denial determination based on a preexisting condition exclusion to the types of adverse decisions that are eligible for review under a group or individual health benefit plan's independent review procedure. In addition, the bill requires every insurer that issues individual health benefit plans to report to the commissioner annually the number of individual health benefit plans issued by the insurer in the preceding year and the number of individual health benefit plans with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

***** ANALYSIS FROM -0912/P1 *****

Preexisting condition exclusions

Under current law, an insurer may impose a preexisting condition exclusion for up to two years under an individual health insurance policy. Under a group health insurance policy, a preexisting condition exclusion generally may not exceed one year. Additionally, under a group health insurance policy, an insurer is limited to imposing a preexisting condition exclusion only with respect to conditions for which

an insured received treatment, or for which treatment was recommended, within six months before the insured's coverage began. Under an individual health insurance policy, an insurer is not limited with respect to how long before an insured's coverage began a condition must have existed to be considered a preexisting condition for an exclusion, and current law does not specify that the insured must have received treatment, or that treatment must have been recommended, for the condition. Thus, an insurer is free to impose a preexisting condition exclusion under an individual health insurance policy for any condition that may have existed at any time during the insured's lifetime that the insurer believes the insured should have known existed or for which the insurer believes the insured should have sought treatment. This bill provides that under an individual health insurance policy, an insurer may impose a preexisting condition exclusion for up to one year for a condition for which an insured received treatment, or for which treatment was recommended, within one year before the insured's coverage began.

Insert A-1 see p. 2

Modifications at renewal of individual health insurance

With some exceptions, an insurer must renew an individual health insurance policy at the option of the insured. At renewal, the insurer may modify the policy form on a uniform basis among all individuals with coverage under that policy form. The bill requires an insurer, at renewal of an individual health insurance policy and at the request of the insured, to modify the benefits or deductible level under the policy, or to provide coverage under a different but comparable individual health insurance policy offered by the insurer without subjecting any individual covered under the policy to additional underwriting.

Insert A-2

Uniform application for individual health insurance

The bill requires the commissioner of insurance to promulgate rules prescribing uniform questions and the format for individual health insurance policy applications, which may not be more than ten pages long. After the effective date of the rules, all insurers offering individual health insurance policies must use the prescribed questions and format on an application for such a policy.

anal: title: head Health and human services

***** ANALYSIS FROM -1157/1 *****

The Health Insurance Risk-Sharing Plan (HIRSP), which is administered by the HIRSP Authority, provides health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, and persons who do not currently have health insurance coverage but who were covered under certain types of health insurance coverage (creditable coverage) for at least 18 months in the past. The lifetime limit of benefits that HIRSP will provide to an individual who is covered under HIRSP is $1,000,000. This bill retains $1,000,000 as the minimum lifetime limit of benefits under HIRSP but allows the HIRSP Authority to increase that lifetime limit.

anal: title: sub Other health and human services

The

***** ANALYSIS FROM -1158/P1 *****

Current law contains a number of provisions related to coverage of dependents under health insurance policies. For example, a health insurer must cover a newly

anal: title: sub sub Dependent coverage

Insert B (p. 5)

born child of an insured from the moment of birth, but may discontinue coverage after 60 days if the insured does not notify the insurer of the birth and pay any additional premium within those 60 days. If a health insurer covers a child of an insured, the health insurer must also cover any child of the insured's child until the insured's child is 18 years old. If a health insurer covers dependents up to a certain age, the health insurer may not terminate coverage of a dependent child who reaches that age if, and while, the child is incapable of self-sustaining employment because of mental retardation or physical handicap and is dependent on the insured for support and maintenance. If a health insurer covers a person as a dependent because the person is a full-time student, the health insurer must continue to cover that person if he or she ceases to be a full-time student due to a medically necessary leave of absence until the happening of one of a number of specified events, such as the person's obtaining other health care coverage or reaching the age at which coverage ends under the terms of the policy for a dependent who is covered because he or she is a full-time student. Current law, however, does not require a health insurer to cover a dependent of an insured up to any particular age or because a dependent is a full-time student.

Under this bill, a health insurer must offer to cover any child of an insured if the child is unmarried, is under 27 years old, and is not eligible for coverage under a group health benefit plan that is provided by his or her employer and for which his or her premium contribution is no greater than the premium amount for his or her dependent coverage under his or her parent's health insurance plan. Additionally, if the child is a full-time student but previously had his or her education interrupted by service in the national guard or reserves, the health insurer must offer dependent coverage for that child for as long as he or she is a full-time student, regardless of age.

The insurer must provide the coverage if the insured requests it, and may require that the insured provide annual written documentation that the dependent child satisfies the criteria for coverage. The bill specifies that an insurer must determine the premium for coverage of a dependent who is over 18 years of age on the same basis as the premium is determined for a younger dependent. The coverage requirement applies to all types of individual and group health insurance policies and plans, including those offered by the state, and to self-insured health plans of counties, cities, villages, towns, school districts, and the state.

The bill does not eliminate any of the other requirements that exist in current law related to coverage of dependents.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

insert C from p. 3

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

***-1158/P1.1* SECTION 1.** 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to ~~(5)~~ (6), 632.885, 632.895 (5m) and (8) to (15), and 632.896.

-1158/P1.2 **SECTION 2.** 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895 (11) to (15).

-1158/P1.3 **SECTION 3.** 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), ~~and~~ (5), and (6), 632.885, 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

-1158/P1.4 **SECTION 4.** 111.91 (2) (t) of the statutes is created to read:

111.91 **(2)** (t) The requirements related to dependent coverage under s. 632.885.

-1158/P1.5 **SECTION 5.** 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.885, 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

-0910/1.1 **SECTION 6.** 149.12 (1) (a) of the statutes is amended to read:

149.12 **(1)** (a) A notice of rejection of coverage from ~~2~~ one or more insurers.

-1157/1.1 **SECTION 7.** 149.12 (2) (c) of the statutes is amended to read:

149.12 **(2)** (c) No person on whose behalf the plan has paid out ~~$1,000,000~~ the lifetime limit under s. 149.14 (2) (a) or more is eligible for coverage under the plan.

-1157/1.2 **SECTION 8.** 149.14 (2) (a) of the statutes is amended to read:

149.14 **(2)** (a) The plan shall provide every eligible person who is not eligible for Medicare with major medical expense coverage. Major medical expense coverage offered under the plan under this section shall pay an eligible person's covered expenses, subject to deductible, copayment, and coinsurance payments, up to a lifetime limit per covered individual of $1,000,000 ~~per covered individual~~ or a higher amount, as determined by the authority.

-1158/P1.6 **SECTION 9.** 185.981 (4t) of the statutes is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.885, 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

-1158/P1.7 **SECTION 10.** 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.885, 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

-0912/P1.1 **SECTION 11.** 601.41 (10) of the statutes is created to read:

601.41 **(10)** UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES. (a) The commissioner shall by rule prescribe uniform questions and the format for applications, which may not exceed 10 pages in length, for individual major medical health insurance policies.

(b) After the effective date of the rules promulgated under par. (a), an insurer may use only the prescribed questions and format for individual major medical health insurance policy applications. The commissioner shall publish a notice in the Wisconsin Administrative Register that states the effective date of the rules promulgated under par. (a).

(c) For purposes of this subsection, an individual major medical health insurance policy includes health coverage provided on an individual basis through an association.

-0911/P1.1 **SECTION 12.** 601.428 of the statutes is created to read:

601.428 Cancellation and rescission reports. Beginning in 2009, every insurer that issues individual health insurance policies shall annually report to the commissioner the total number of individual health insurance policies that the insurer issued in the preceding year and the total number of individual health insurance policies with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

-1158/P1.8 **SECTION 13.** 609.74 of the statutes is created to read:

609.74 Coverage of dependents. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.885.

-0912/P1.2 **SECTION 14.** 631.36 (5) (b) (intro.) of the statutes is amended to read:

631.36 **(5)** (b) *Exception.* (intro.) Paragraph (a) does not apply if the only change that is adverse to the policyholder is a premium increase and if ~~either~~ any of the following applies to the premium increase:

-0912/P1.3 **SECTION 15.** 631.36 (5) (b) 3. of the statutes is created to read:

631.36 **(5)** (b) 3. The premium increase results from a modification in the benefits or deductible level requested by the insured at the time of coverage renewal under s. 632.7495 (1) (b) 2. a.

-0911/P1.2 **SECTION 16.** 632.746 (2) (e) of the statutes is amended to read:

632.746 **(2)** (e) Paragraphs (c) and (d) do not apply to an individual after the end of the first continuous period during which the individual was not covered under any creditable coverage for at least ~~63~~ 90 days. For purposes of this paragraph, any waiting period or affiliation period for coverage under a group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the group health plan or group health benefit plan.

in addition to s. 632.746(3)(b)

****NOTE: I assumed you wanted to change the above paragraph, ~~also~~. Let me know if you do not.

-0911/P1.3 **SECTION 17.** 632.746 (3) (b) of the statutes is amended to read:

632.746 **(3)** (b) With respect to enrollment of an individual under a group health plan or a group health benefit plan, a period of creditable coverage after which the individual was not covered under any creditable coverage for a period of at least ~~63~~ 90 days before enrollment in the group health plan or group health benefit plan may not be counted. For purposes of this paragraph, any waiting period or affiliation period for coverage under the group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the group health plan or group health benefit plan.

-0912/P1.4 **SECTION 18.** 632.7495 (1) (b) of the statutes is renumbered 632.7495 (1) (b) (intro.) and amended to read:

632.7495 **(1)** (b) (intro.) At the time of coverage renewal, ~~the~~ all of the following apply:

1. The insurer may modify the individual health benefit plan coverage policy form as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

-0912/P1.5 **SECTION 19.** 632.7495 (1) (b) 2. of the statutes is created to read:

632.7495 **(1)** (b) 2. The insurer shall, at the request of the insured individual, do either of the following:

a. Modify the benefits or deductible level, or both, under the individual health benefit plan that is being renewed.

b. Provide coverage to the insured individual under a different but comparable individual health benefit plan currently offered by the insurer, without subjecting any individual covered under the individual health benefit plan to additional underwriting.

-0912/P1.6 **SECTION 20.** 632.76 (2) (a) of the statutes is amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after ~~2 years~~ 12 months from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746.

-0912/P1.7 **SECTION 21.** 632.76 (2) (ac) of the statutes is created to read:

632.76 **(2)** (ac) An individual disability insurance policy, as defined in s. 632.895 (1) (a), may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 12 months before the effective date of coverage.

-0912/P1.8 **SECTION 22.** 632.76 (2) (b) of the statutes is amended to read:

632.76 **(2)** (b) Notwithstanding par. (a), no claim for loss incurred or disability commencing after 6 months from the date of issue of a medicare supplement policy, medicare replacement policy or long-term care insurance policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage. ~~A~~ Notwithstanding par. (ac), a medicare supplement policy, medicare replacement policy, or long-term care insurance policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. Notwithstanding par. (a), if on the basis of information contained in an application for insurance a medicare supplement policy, medicare replacement policy, or long-term care insurance policy excludes from coverage a condition by name or specific description, the exclusion must terminate no later than 6 months after the date of issue of the medicare supplement policy, medicare replacement policy, or long-term care insurance policy. The commissioner may by rule exempt from this paragraph certain classes of medicare supplement policies, medicare replacement policies, and long-term care insurance policies, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

-0911/P1.4 **SECTION 23.** 632.835 (title) of the statutes is amended to read:

632.835 (title) **Independent review of ~~adverse and experimental treatment~~ coverage denial determinations.**

-0911/P1.5 **SECTION 24.** 632.835 (1) (ag) of the statutes is created to read:

632.835 **(1)** (ag) "Coverage denial determination" means an adverse determination, an experimental treatment determination, a preexisting condition exclusion denial determination, or the rescission of a policy or certificate.

-0911/P1.6 **SECTION 25.** 632.835 (1) (cm) of the statutes is created to read:

632.835 **(1)** (cm) "Preexisting condition exclusion denial determination" means a determination by or on behalf of an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a preexisting condition exclusion, as defined in s. 632.745 (23).

-0911/P1.7 **SECTION 26.** 632.835 (2) (a) of the statutes is amended to read:

632.835 **(2)** (a) Every insurer that issues a health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and obtain an independent review of ~~an adverse determination or an experimental treatment~~ a coverage denial determination made with respect to the insured.

-0911/P1.8 **SECTION 27.** 632.835 (2) (b) of the statutes is amended to read:

632.835 **(2)** (b) If ~~an adverse determination or an experimental treatment~~ a coverage denial determination is made, the insurer involved in the determination shall provide notice to the insured of the insured's right to obtain the independent review required under this section, how to request the review, and the time within which the review must be requested. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review

under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the insured.

-0911/P1.9 **SECTION 28.** 632.835 (2) (bg) 3. of the statutes is amended to read:

632.835 **(2)** (bg) 3. For any ~~adverse determination or experimental treatment~~ coverage denial determination for which an explanation of benefits is not provided to the insured, the insurer provides a notice that the insured may have a right to an independent review after the internal grievance process and that an insured may be entitled to expedited, independent review with respect to an urgent matter. The notice shall also include a reference to the section of the policy or certificate that contains the description of the independent review procedure as required under subd. 1. The notice shall provide a toll-free telephone number and website, if appropriate, where consumers may obtain additional information regarding internal grievance and independent review processes.

-0911/P1.10 **SECTION 29.** 632.835 (2) (c) of the statutes is amended to read:

632.835 **(2)** (c) Except as provided in par. (d), an insured must exhaust the internal grievance procedure under s. 632.83 before the insured may request an independent review under this section. Except as provided in sub. (9) (a), an insured who uses the internal grievance procedure must request an independent review as provided in sub. (3) (a) within 4 months after the insured receives notice of the disposition of his or her grievance under s. 632.83 (3) (d).

-0911/P1.11 **SECTION 30.** 632.835 (2) (e) of the statutes is created to read:

632.835 **(2)** (e) Nothing in this section requires an insured to request an independent review before commencing a civil action relating to a coverage denial determination.

-0911/P1.12 **SECTION 31.** 632.835 (3) (a) of the statutes is amended to read:

632.835 **(3)** (a) To request an independent review, an insured or his or her authorized representative shall provide timely written notice of the request for independent review, and of the independent review organization selected, to the insurer that made or on whose behalf was made the ~~adverse or experimental treatment~~ coverage denial determination. The insurer shall immediately notify the commissioner and the independent review organization selected by the insured of the request for independent review. The insured or his or her authorized representative must pay a $25 fee to the independent review organization. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the insurer to the insured or his or her authorized representative. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

-0911/P1.13 **SECTION 32.** 632.835 (3) (e) of the statutes is amended to read:

632.835 **(3)** (e) In addition to the information under pars. (b) and (c), the independent review organization may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. The insurer and the insured shall submit to the other party to the independent review any information submitted to the independent review organization under this paragraph and pars. (b) and (c). If, on the basis of any additional information, the insurer reconsiders the insured's grievance and determines that the treatment that was the subject of the grievance should be covered, or that the policy or certificate that was rescinded should be reinstated, the independent review is terminated.

-0911/P1.14 **SECTION 33.** 632.835 (3) (f) of the statutes is renumbered 632.835 (3) (f) 1. and amended to read:

632.835 **(3)** (f) 1. If the independent review is not terminated under par. (e), the independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the insurer. ~~A~~ Except as provided in subd. 2., a decision of an independent review organization is binding on the insured and the insurer.

-0911/P1.15 **SECTION 34.** 632.835 (3) (f) 2. of the statutes is created to read:

632.835 **(3)** (f) 2. A decision of an independent review organization regarding a preexisting condition exclusion denial determination or a rescission is not binding on the insured.

-0911/P1.16 **SECTION 35.** 632.835 (3m) (a) of the statutes is amended to read:

632.835 **(3m)** (a) A decision of an independent review organization regarding an adverse determination or a preexisting condition exclusion denial determination must be consistent with the terms of the health benefit plan under which the adverse determination or preexisting condition exclusion denial determination was made.

-0911/P1.17 **SECTION 36.** 632.835 (6m) (a) of the statutes is amended to read:

632.835 **(6m)** (a) ~~Be~~ Unless the review relates to a rescission, be a health care provider who is expert in treating the medical condition that is the subject of the review and who is knowledgeable about the treatment that is the subject of the review through current, actual clinical experience.

****NOTE: Because rescissions do not necessarily relate to a specific medical condition, I have excluded reviews of rescissions from the above requirement. Is this amendment okay? Would you prefer to treat the above paragraph differently?

***-0911/P1.18* SECTION 37.** 632.835 (7) (b) of the statutes is amended to read:

632.835 **(7)** (b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable to any person for damages attributable to the insurer's or plan's actions taken in compliance with any decision regarding an adverse determination or an experimental treatment determination rendered by a certified independent review organization.

***-0911/P1.19* SECTION 38.** 632.835 (8) of the statutes is renumbered 632.835 (8) (a) and amended to read:

632.835 **(8)** (a) *Adverse and experimental treatment determinations.* The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section for adverse determinations and experimental treatment determinations and shall publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating with respect to adverse determinations and experimental treatment determinations.

***-0911/P1.20* SECTION 39.** 632.835 (8) (b) of the statutes is created to read:

632.835 **(8)** (b) *Preexisting condition exclusion denials and rescissions.* The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section for preexisting condition exclusion denial determinations and rescissions and shall publish a notice in the Wisconsin

Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating with respect to preexisting condition exclusion denial determinations and rescissions.

-0911/P1.21 **SECTION 40.** 632.835 (9) of the statutes is renumbered 632.835 (9) (a) and amended to read:

632.835 **(9)** (a) *Adverse and experimental treatment determinations.* The independent review required under this section with respect to an adverse determination or an experimental treatment determination shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000, but before June 15, 2002, with respect to an adverse determination or an experimental treatment determination must request an independent review no later than 4 months after June 15, 2002.

-0911/P1.22 **SECTION 41.** 632.835 (9) (b) of the statutes is created to read:

632.835 **(9)** (b) *Preexisting condition exclusion denials and rescissions.* The independent review required under this section with respect to a preexisting condition exclusion denial determination or a rescission shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the date stated in the notice published in the Wisconsin Administrative Register by the commissioner under sub. (8) (b).

-1158/P1.9 **SECTION 42.** 632.885 of the statutes is created to read:

632.885 Coverage of dependents. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Insured" includes an enrollee.

(c) "Self-insured health plan" has the meaning given in s. 632.745 (24).

(2) REQUIREMENT TO OFFER DEPENDENT COVERAGE. (a) Subject to ss. 632.88 and 632.895 (5), every insurer that issues a disability insurance policy, and every self-insured health plan, shall offer and, if so requested by an applicant or an insured, provide coverage for a child of the applicant or insured as a dependent of the applicant or insured if the child satisfies all of the following criteria:

1. The child is less than 27 years of age.

2. The child is not married.

3. The child is not eligible for coverage under a group health benefit plan, as defined in s. 632.745 (9), that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a dependent under this section.

(b) Notwithstanding par. (a) 1., if the child served on active duty in the national guard or in a reserve component of the U.S. armed forces, the coverage requirement under this section applies, subject to par. (a) 2. and 3., as long as the child is a full-time student, regardless of the child's age.

****NOTE: The instruction was that the child's education was interrupted by service in the national guard or reserves. Do you want to require coverage of any full-time student who served in the national guard or reserves, or do you want to limit the requirement to a child who actually completed a certain amount of higher education before serving in the national guard or reserves? What if they received an undergraduate degree before serving and have now gone back to school for another degree? Do you want to require that they were actually attending school when they were called to active duty? If so, must they have been a full-time student at the time and under the age of 27? Does it matter how long they waited before returning to school after their active duty terminated?

(3) PREMIUM DETERMINATION. An insurer or self-insured health plan shall determine the premium for coverage of a dependent who is over 18 years of age on

the same basis as the premium is determined for coverage of a dependent who is 18 years of age or younger.

(4) DOCUMENTATION OF CRITERIA SATISFACTION. An insurer or self-insured health plan may require that an applicant or insured seeking coverage of a dependent child provide written documentation, initially and annually thereafter, that the dependent child satisfies the criteria for coverage under this section.

-1158/P1.10 **SECTION 43.** 632.895 (15) (a) of the statutes is amended to read:

632.895 **(15)** (a) Subject to pars. (b) and (c), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, that provides coverage for a person as a dependent of the insured because the person is a full-time student, including the coverage under s. 632.885 (2) (b), shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student.

****NOTE: Is this amendment okay? See my drafter's note regarding how to treat s. 632.895 (15) (c).

-0910/1.2 **SECTION 44. Initial applicability.**

(1) This act first applies to persons who apply for coverage under the Health Insurance Risk-Sharing Plan on the effective date of this subsection.

-0912/P1.9 **SECTION 45. Nonstatutory provisions.**

(1) RULES. The commissioner of insurance shall submit in proposed form the rules required under section 601.41 (10) (a) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 12th month beginning after the effective date of this subsection.

SECTION 46. Initial applicability.

-0912/P1.10 (1) MODIFICATIONS AT RENEWAL. The treatment of section 632.7495 (1) (b) 2. of the statutes first applies to individual health benefit plans that are renewed on the effective date of this subsection.

(2) PREEXISTING CONDITION EXCLUSIONS. The treatment of section 632.76 (2) (a), (ac), and (b) of the statutes first applies to individual disability insurance policies that are issued or renewed on the effective date of this subsection.

-1158/P1.11 (3) This act first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

-1158/P1.12 **SECTION 47. Effective date.**

(1) This act takes effect on the first day of the 7th month beginning after publication.

(END)

Insert 20-2 ✓

D-note

INSERT A-2

to issue comparable coverage to the insured that the insurer currently offers that has more limited benefits or a higher deductible or to provide a higher deductible under the insured's current coverage. If the insurer issues the alternative coverage, the insurer may not rate the coverage for any health status that did not apply when the insured applied for the original coverage. An insurer issuing individual policies must mail to each insured under an individual policy issued by the insurer a notice that informs the insured of his or her right to elect alternative coverage and that describes the alternatives available to the insured and the procedure for electing the alternative coverage

(END OF INSERT A-2)

INSERT 9-16

SECTION 1. 632.7497 of the statutes is created to read:

632.7497 Modifications at renewal. (1) In this section, "individual major medical or comprehensive health benefit plan" includes coverage under a group health benefit plan that is underwritten on an individual basis and issued to individuals or families.

(2) An insurer that issues an individual major medical or comprehensive health benefit plan shall, at the time of a coverage renewal, at the request of an insured, permit the insured to do either of the following:

(a) Change his or her coverage to a different but comparable individual major medical or comprehensive health benefit plan currently offered by the insurer with more limited benefits or with a higher deductible.

(b) Modify his or her existing coverage by electing an optional higher deductible, if any, under the individual major medical or comprehensive health benefit plan.

(3) (a) The insurer may not impose any new preexisting condition exclusion under the new or modified coverage under sub. (2) that did not apply to the insured's

Ins 9-16 cont'd

original coverage and shall allow the insured credit under the new or modified coverage for the period of original coverage.

(b) For the new or modified coverage, the insurer may not rate for health status other than on the insured's health status at the time the insured applied for the original coverage and as the insured disclosed on the original application.

(4) (a) Annually, the insurer shall mail to each insured under an individual major medical or comprehensive health benefit plan issued by the insurer, a notice that includes all of the following information:

1. That the insured has the right to elect alternative coverage as described in sub. (2).

2. A description of the alternatives available to the insured.

3. The procedure for making the election.

(b) The insurer shall mail the notice under par. (a) not more than 3 months nor less than 60 days before the renewal date of the insured's plan.

(5) (a) Nothing in this section requires an insurer to issue alternative coverage under sub. (2) if the insured's coverage may be nonrenewed or discontinued under s. 632.7495 (2), (3) (b), or (4).

(b) Notwithstanding s. 600.01 (1) (b) 3. and 4., this section applies to a group health benefit plan described in s. 600.01 (1) (b) 3. or 4. if that group health benefit plan is an individual major medical or comprehensive health benefit plan as defined in sub. (1).

(END OF INSERT 9-16)

INSERT 20-2 193

SECTION 9126. Nonstatutory provisions; Insurance.

(1) RULES FOR UNIFORM APPLICATION. The commissioner of insurance shall submit in proposed form the rules required under section 601.41 (10) (a) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 12th month beginning after the effective date of this subsection.

SECTION 9326. Initial applicability; Insurance.

(1) MODIFICATIONS AT RENEWAL. The treatment of section 632.7497 of the statutes first applies to individual major medical or conprehensive health benefit plans that are renewed on the effective date of this subsection.

(2) PREEXISTING CONDITION EXCLUSIONS. The treatment of section 632.76 (2) (a), (ac), and (b) of the statutes first applies to individual disability insurance policies that are issued or renewed on the effective date of this subsection.

(3) DEPENDENT COVERAGE. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (t), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.74, 632.885, and 632.895 (15) (a) of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

ins 20-2 3 of 3

(c) Governmental or school district self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 9357. Initial applicability; Other.

(1) HEALTH INSURANCE RISK-SHARING PLAN ELIGIBILITY. The treatment of section 149.12 (1) (a) of the statutes first applies to persons who apply for coverage under the Health Insurance Risk-Sharing Plan on the effective date of this subsection.

SECTION 9426. Effective dates; Insurance.

(1) DEPENDENT COVERAGE. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (t), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.74, 632.885, and 632.895 (15) (a) of the statutes and Section 9357 (3) of this act take effect on first day of the 7th month beginning after publication.

(END OF INSERT 20-2)

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1538/P1dn
PJK:...
jld

date

10/3

Submitted

For the provision related to modifications of individual policies at renewal (proposed s. 632.7497), I used the language proposed by OCI in the drafting instructions. I have no idea if the way in which I interpreted proposed s. 632.7497 (5) (b) is correct.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

1538/P1dn
LRB-0911/P1dn
PJK:nwn:ph

January 13, 2009

2003

of OCI

In this draft, independent reviews of preexisting condition exclusion denial determinations and rescissions will be available under both group and individual health insurance policies, because existing s. 632.835 applies to both types of policies. As you may recall, Fred Nepple mentioned that there may be an ERISA preemption issue with requiring independent reviews of rescissions of employer-provided group health insurance policies. If you have concerns about this, or would like further information on this issue, please contact Fred. If necessary, I'm sure that language could be crafted to make independent reviews of rescissions apply only with respect to individual policies.

at 266-7726

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1158/P1dn
PJK:bjk:rs

December 23, 2008

3883
proposed s. 632.885

I left all of the sections in current law that apply to dependent coverage as is in this draft [see ss. 632.88 and 632.895 (5), (5m), and (15)], except for the amendment I made to s. 632.895 (15) (a). Section 632.895 (15) applies to an insurer that covers a dependent because he or she is a full-time student. If this draft becomes law, s. 632.895 (15) would apply to: 1) any policy that extends coverage for dependents beyond age 26 if they are full-time students (probably none or very few, but it is theoretically possible); and 2) any policy covering a person who served in the national guard or reserves and is now a full-time student. You may be able to think of other possibilities. I think s. 632.895 (15) can coexist with ~~this draft~~. However, you will have to let me know which of the happenings under s. 632.895 (15) (c) you want to apply to a person whose coverage under s. 632.895 (15) stems from proposed s. 632.885 (2) (b). For example, even though coverage is not terminated on the basis of age under proposed s. 632.885 (2) (b) if the person is a full-time student, do you want their coverage terminated on the basis of age if they are on medical leave and not actually a full-time student, as under s. 632.895 (15) (c) 5.? Let me know, also, if you want any of the current law dependent coverage sections to be treated differently from how I have treated them in this draft.

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the person is

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1538/P1dn
PJK:jld:ph

January 20, 2009

For the provision related to modifications of individual policies at renewal (proposed s. 632.7497), I used the language submitted by OCI in the drafting instructions. I have no idea if the way in which I interpreted proposed s. 632.7497 (5) (b) is correct.

In this draft, independent reviews of preexisting condition exclusion denial determinations and rescissions will be available under both group and individual health insurance policies, because existing s. 632.835 applies to both types of policies. Fred Nepple of OCI mentioned that there may be an ERISA preemption issue with requiring independent reviews of rescissions of employer-provided group health insurance policies. If you have concerns about this, or would like further information on this issue, please contact Fred at 266-7726. If necessary, I'm sure that language could be crafted to make independent reviews of rescissions apply only with respect to individual policies.

I left all of the sections in current law that apply to dependent coverage as is in this draft [see ss. 632.88 and 632.895 (5), (5m), and (15)], except for the amendment I made to s. 632.895 (15) (a). Section 632.895 (15) applies to an insurer that covers a dependent because he or she is a full-time student. If proposed s. 632.885 becomes law, s. 632.895 (15) would apply to: 1) any policy that extends coverage for dependents beyond age 26 if they are full-time students (probably none or very few, but it is theoretically possible); and 2) any policy covering a person who served in the national guard or reserves and is now a full-time student. You may be able to think of other possibilities. I think s. 632.895 (15) can coexist with proposed s. 632.885. However, you will have to let me know which of the happenings under s. 632.895 (15) (c) you want to apply to a person whose coverage under s. 632.895 (15) stems from proposed s. 632.885 (2) (b). For example, even though coverage is not terminated on the basis of age under proposed s. 632.885 (2) (b) if the person is a full-time student, do you want the person's coverage terminated on the basis of age if the person is on medical leave and not actually a full-time student, as under s. 632.895 (15) (c) 5.? Let me know, also, if you want any of the current law dependent coverage sections to be treated differently from how I have treated them in this draft.

1-25

for Sue Jablonsky

for s. 632.895 (15) (dependent coverage)

keep but modify (a)

repeal (b)

for (c), repeal 1.

? 2. → only if employer offers

keep 3.

? 4. only married

modify 5. specify 27 years old

keep 6.

repeal 7.

health care coverage

offer but provide only if requested? ← offer required or just provide it?

Reforms Impacting Only Individual Health Insurance Coverage

1. HIRSP

- Current law requires individuals to receive a notice of rejection from at least 2 insurers prior to being eligible for HIRSP. Additionally the major medical coverage offered by HIRSP is subject to a lifetime limit of $1 million.
- Proposed change:
  - Allow individuals to be HIRSP eligible after receiving at least 1 notice of rejection.
  - Allow higher lifetime limits as approved by the HIRSP authority.

2. Maximum Pre-Existing Condition Exclusion Period

- Current law allows a pre-existing exclusion period for individual health insurance up to 2 years. If an insurer investigates claims and determines they are for pre-existing conditions, the insurer can deny coverage for that condition during the exclusion period.
- Proposed change: Reduce the pre-existing condition exclusion period to 1 year.

3. Maximum Pre-Existing Condition Look Back Period

- Current law does not limit the amount of time prior to the purchase of a policy that an insurer can investigate to find evidence of a pre-existing condition.
- Proposed change: Limit the maximum look back period for pre-existing conditions to 1 year.

4. Move to the Objective Standard for Pre-Existing Condition Determinations

- Current law requires use of the prudent person standard to determine whether a condition is pre-existing, which includes conditions that were not diagnosed but for which a prudent person would have sought medical advice or treatment. The objective standard is used for Medicare supplement policies sold in Wisconsin as well as for small group health insurance coverage.
- Proposed change: Adopt the objective standard which allows only those conditions for which someone received medical advice, diagnosis, care or treatment prior to enrollment.

5. Modification of Coverage at Renewal Without Additional Underwriting

- Proposed change:
  - An insurer may not restrict an individual from changing their coverage to a comparable or more limited plan or to increase optional deductibles at the time of renewal.
  - An insurer may not rate for health status except at the time the original application was taken and may not impose any new pre-existing condition exclusions that did not apply to the original coverage. The insured should be credited under for the original period of coverage.
  - Insurers must annually notify insureds of these rights by mail.

6. Annual Reporting

- Proposed change: Require insurers to annually report the number of individual health insurance policies issued and the number of policies under which the insurer initiated or completed a cancellation or rescission.

7. Uniform Major Medical Application Underwriting Questions

- Proposed change: Similar to the uniform application for the small group market, the Commissioner will prescribe the underwriting questions and the format to be used on applications by rule and require insurers to use only that form.

Other Health Insurance Reforms

1. Establish BadgerChoice Insurance Connector Without Community Rating

OCI PROPOSALS FOR HEALTH INSURANCE REFORMS

Reforms Impacting Both Group and Individual Health Insurance Coverage

1. External Appeal of Rescission or Pre-existing Condition Exclusions

- Current law allows for an independent review of adverse and experimental treatment determinations.
- Proposed change:
  - Allow for an independent review of rescissions and pre-existing exclusion denial determinations.
  - Do not require an insured to request an independent review prior to commencing civil action relating to a determination.
  - The decision of the independent review organization would not be binding on the insured.

2. Creditable Coverage

- Current law specifies that if a person loses health insurance but regains coverage within 63 days, they can apply creditable coverage to the pre-existing condition exclusion period on the new group policy.
- Proposed change: Increase the timeframe from 63 days to 90 days.

3. Modifications to Rate Restrictions

- Current law:
  - Rate adjustments based on health status, including occupation and claims history, are limited to 15% per year.
  - No restrictions on rate changes for case characteristics such as age, sex, geography or group size.
  - A policy's rate can vary no more than +/- 30% of the midpoint for similar policies.
- Proposed Change:
  - Direct the Commissioner to establish in rule that variance in rates for similar policies cannot exceed +/- 20% the midpoint.
  - Provide the Commissioner the authority to review the definition of case characteristics that are excluded from rate restrictions and amend the list by rule.

4. Mandate coverage of adult children on parent's individual or group policy

- Proposed Change:
  - Child must be under age 27 and unmarried.
  - Either ineligible for employer coverage or the adult child's employer does not offer coverage for a premium contribution that is the same or less than the employee premium contribution for coverage as a dependent under their parent's health plan.
  - Mandates coverage of child of any age whose education was interrupted by service in the National Guard or Reserves.
  - Parent must request coverage and insurer may require annual written documentation of Eligibility.
  - Cost of coverage of adult child included in the premium on the same basis as other dependent coverage.

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